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ABSTRACT

This study sought to show that motivated biases can be shown for positive, as well as negative, behaviors. In the first study college students (N=151) estimated how often they and their fellow students engaged in various positive and negative health-related behaviors. Results indicated all negative behaviors yielded the predicted pattern: subjects believed they engaged in the behavior less often than did their average peer. The more important finding was that the bias observed for positive behaviors was substantially weaker than that observed for negative behaviors. In the second study college students (N=138) generated lists of either positive or negative health behaviors. In a subsequent questionnaire subjects rated how often they and their same-age, same-sex peers engaged in the behaviors they had listed. Of the 253 negative behaviors listed in which self and peer estimates differed, 77% yielded the predicted bias: subjects thought others committed these behaviors more often. By contrast, a significantly lower 50% of the 204 cases where self and peer estimates differed showed subjects estimating their own positive behaviors as more frequent than those of their peers. Once again, self-peer biases were stronger for negative behaviors, and there was not even evidence of bias for positive behaviors. (ABL)

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Constructing Social Reality: Greater Bias for Negative than for Positive Behaviors?

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People are quite creative at constructing social reality in such a way that places them in a desired light. They overestimate the number of people agreeing with their views (e.g., Ross, Greene, & House, 1977), yet when they have agreed to perform a desirable act (e.g., give blood), they underestimate the percentage of others who would do the same (e.g., Goethals, 1986).

With this in mind, one wonders about the relative strength of people's construction strategies. For example, are we more likely to show biases in our perceptions of other people's undesirable behaviors than of their desirable behaviors? Consider the health domain. People consistently show unrealistic optimism about their future health (e.g., Weinstein, 1980). It might be argued that underlying such illusions is the belief that one's health habits are superior to those of others. For instance, one way for people to hold that they are less likely than others to contract heart disease is to believe that they eat less red meat and more low-fat foods than others do. However, might they be more likely to overestimate their peers' red meat consumption than they are to underestimate their peers' lowfat food consumption? In general, might we observe any difference in the magnitude of bias inherent in people's estimates of their peers' health-threatening behavior than we would in their estimates of their peers' health-promoting behavior?

Surprisingly, past research is incapable of providing an answer, because much of the work on perception of risk factors has been devoted to lay estimates of negative, health-threatening behavior (e.g., Weinstein, 1984). Consequently, while it is clear that people believe they commit negative behaviors less often than their peers do, it is less clear that people also believe they commit positive behaviors more often than their peers do. This neglect raises the possibility that people believe they commit all behaviors, regardless of valence, less often than their peers do, perhaps because they extrapolate too much from what they see their peers doing.

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The first aim of this investigation was to argue against this cognitive interpretation of past work by showing that motivated biases can also be shown for positive behaviors. Second, and more importantly, we wondered whether the biases found for negative behaviors might be more or less robust than those for positive behaviors.

In the first study, 151 University of Waterloo students estimated how often they and their fellow students (same age and same sex) engaged in various positive and negative health-related behaviors. It may be seen in the upper half of Table 1 that all negative behaviors yielded the predicted pattern: subjects believed they engaged in the behavior less often than did their average peer. Indexing all negative behaviors reveals higher estimated frequencies for peers than for the self, $t(150) = 13.84$, $p < .001$. Meanwhile, as seen in the bottom half of Table 2, subjects thought they engaged in positive behaviors more often than their peers, with the predicted pattern found for 5 of the 7 behaviors. Indexing these behaviors yields higher overall estimates for self than for peers, $t(150) = 2.27$, $p < .05$. These findings support a motivational explanation of past work.

The more important finding, however, is that the bias observed for positive behaviors is substantially weaker than that observed for negative behaviors. Before enlisting a theoretical explanation for this, it is necessary to ensure that these results were not an artifact of the specific behaviors used in the study. In a second study, we asked 138 Princeton students to generate lists of either positive or negative health behaviors. They were encouraged to list any behaviors that one or more Princeton students commit. Then, in a subsequent questionnaire, subjects rated how often they and their same-age, same-sex peers at Princeton engaged in the behaviors they had listed. Of the 253 negative behaviors listed in which self and peer estimates differed, 77% yielded the predicted bias: subjects thought others committed these behaviors more often. By contrast, a significantly lower 50% of the 204 cases where self and peer estimates differed showed subjects estimating their own positive behaviors as more frequent than those of their peers ($z = 6.03$, $p < .0001$). Once again, self-peer biases were stronger for negative behaviors, and here there was not even evidence of bias for positive behaviors. While these results still do not support a cognitive interpretation of past work (to do so, subjects would

have had to believe they engaged in positive behaviors less often than others do, as they believe for negative behaviors), they are quite intriguing.

We are presently exploring a variety of accounts for this attenuation of bias for positive behaviors. For instance, in another study we asked 194 Princeton students to rate the importance to them of each of the behaviors used in our first study. Subjects cared more about their frequency of positive behaviors ($M = 5.7$) than of negative behaviors ($M = 4.7$), $t(193) = 11.14$, suggesting perhaps that biases are lessened for positive behaviors because the importance of them fuels the motivation to be accurate. Moreover, the same subjects reported that their positive health behaviors would add more years to their lives ($M = 6.0$) than their negative health behaviors would subtract ($M = 3.9$), again suggesting they are more concerned about positive behaviors. In another study, positive behaviors ($M = 4.36$) were rated as less observable in everyday interaction than were negative behaviors ($M = 5.76$), $t(30) = 7.52$, $p < .001$. These results lead to the surprising conclusion that people are more accurate when making judgments about behaviors they deem most important and least observable in others.

It is conceivable that the structure of memory is such that it is easier to suppress memory of instances where one acted negatively than it is to supplement memory with imagined instances of positive behaviors, leading to greater bias for negative behaviors. We are presently considering this possibility.

Differences in the relative magnitude of social construction biases may have enormous implications. First, these results suggest that past research may have overestimated the extent of bias in people's health-related beliefs. Second, if people maintain more biased beliefs about the things they do to hurt themselves, perhaps we must design interventions that either frame negative behaviors like smoking in positive terms such as the benefits of not smoking, or focus almost exclusively on changing beliefs about negative behaviors. Finally, understanding the mechanisms underlying the observed difference might suggest hypotheses about how optimistic biases are generated and maintained.

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Table 1

Estimated Self and Average Peer Frequencies of Committing Negative and Positive Health Behaviors, Study 1

Behavior	Estimated Self Frequency[1]	Estimated Average Peer Frequency[2]	t(150)
Negative behaviors:			
Sunbathing	3.36	4.52	8.87***
Drinking coffee	0.79	2.16	10.89***
Adding butter	2.69	3.50	8.04***
Eating salty foods	4.32	5.16	7.05***
Driving speed	4.10	4.37	2.96**
Attending loud events	4.36	5.50	8.70***
Walking alone at night	3.81	4.06	1.79+
Driving in bad weather (%)	44.79	53.08	4.10***
Getting X-rays	2.46	2.72	3.68***
Positive behaviors:			
Eating fruit	5.48	5.15	–3.00**
Wearing seat belt (%)	91.06	73.91	–11.27***
Using suntan lotion (%)	50.86	63.18	4.25***[3]
Brushing teeth	6.31	6.10	–3.63***
Eating lowfat foods	4.40	4.13	–1.87+
Taking vitamins	2.79	2.97	1.11
Getting medical checkups	2.72	2.65	–0.79

+p < .10. *p < .05. **p < .01. ***p < .001. N = 151.

[1]Based on 7-point scales with scale points appropriate to behavior.
[2]Same questions as for self frequencies, but made for average same-sex, same-age Waterloo student.
[3]Difference is significant in direction opposite to prediction.